PROCEEDINGS OF THE BROWN COUNTY HUMAN SERVICES BOARD

Pursuant to Section 19.84 Wis. Stats, a regular meeting of the **Brown County Human Services Board** was held on Thursday, July 10, 2014 in Board Room A of the Sophie Beaumont Building
– 111 North Jefferson Street, Green Bay, WI

Present: Chairman Tom Lund

Paula Laundrie, Helen Smits, Bill Clancy, Craig Huxford, Carole Andrews, John

Van Dyck

Excused: Susan Hyland, JoAnn Graschberger

Also

Present: Jeremy Kral, Executive Director

Nancy Fennema, Director of Community Programs

Kristin Madison, Accountant Supervisor

1. Call Meeting to Order:

The meeting was called to order by Chairman Tom Lund at 5:15 pm.

2. Approve/Modify Agenda:

ANDREWS/HUXFORD moved to approve the agenda.

The motion was passed unanimously.

3. Approve Minutes of June 12, 2014 Human Services Board Meeting:

CLANCY/LAUNDRIE moved to approve the minutes dated June 12, 2014. The motion was passed unanimously.

4. Executive Director's Report

Executive Director Jeremy Kral stated he did not do a separate report since the 2013 Annual Report has been completed. Everyone was given a copy of the report.

County Board Member Van Dyck entered at 5:17 p.m.

5. 2013 Annual Report

Kral stated when he had done annual reports in previous counties and wanted to do one here for Brown County. The document contains input from many of leadership team members and the goal was to give a person an overview of how Human Services serves Brown County citizens. Over time, we will be able to see trends and do comparisons with the data provided in the packet.

Q: Citizen Board Member Smits stated that since we have spent a considerable amount of funds to remodel the CTC to create a CBRF, she is curious how the results are matching what we expected. A: Kral stated that the statistics for the Bay Haven CBRF are in the agenda packet as well as a financial report which gives some more information on the status.

Fennema stated that we have filled the Children, Youth & Families Manager position. Shirley Zahn will be joining us form Winnebago County, starting August 18. She was a Child Protective Services supervisor and will bring a lot of relevant experience.

- Q: Chairman Lund asked if Kral would provide an update on the van that was discussed extensively at the last meeting.
- A: Kral stated he is happy to report that only a few days after the last meeting, we were able to secure a very affordable van through a closed bidding process. We used the funding recovered from the previous van and secured the vehicle through Red Cross. The key person to give credit to is Genny Willemon, Office Manager at the CTC.

The board agreed to review the annual report and bring it back on the agenda for next month.

CLANCY/LAUNDRIE moved to suspend the rules and take items 4 & 5 together. Motion was carried unanimously.

SMITS/HUXFORD moved to receive and place items 4 & 5 on file. Motion was carried unanimously.

6. Financial Report

Madison had submitted a written report with the board packet agenda.

ANDREWS/LAUNDRIE moved to receive and place on file. Motion was carried unanimously.

7. Statistical Reports:

Please refer to the packet which includes this information.

8. Approval for New Non-Continuous Vendor:

Please refer to the packet which includes this information.

9. Request for New Vendor Contract:

Please refer to the packet which includes this information.

10. Other Matters:

- Q: Citizen Board Member Huxford asked what the status is for filling the position funded by the TAD grant.
- A: Kral stated we are still recruiting for the case manager position. For the TAD Coordinator position, the board will need to act on a resolution to create that position. This is a relatively new system so finding the right person with experience to put together a whole program will be a challenge.
- Q: Citizen Board Member Laundrie asked if the position would works with diversion at CTC or the one on Danz Street.
- A: Kral said neither, stating that it would be a diversion from the criminal court process. Many individuals who enter the jail will participate in a screen which will determine if they will go through the formal prosecutory track or a specialty court.

Next Meeting: Thursday, August 14, 2014 5:15 p.m. – Sophie Beaumont Building, Board Room A

11. Adjourn Business Meeting:

HUXFORD/ANDREWS moved to adjourn; motion passed unanimously. Chairman Lund adjourned the meeting at 5:34 p.m.

Respectfully Submitted,

Kara Navin Recording Secretary

Brown County Department of Human Services Annual Report 2013

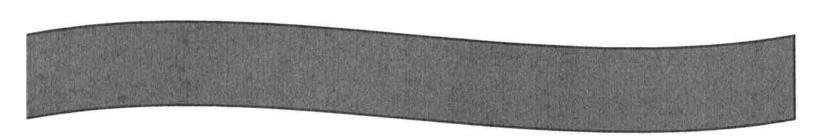


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EXECUTIVE SUMMARY

The reader will find this report on the work of the Brown County Human Services Department in calendar year 2013 to be thorough and informative. A conscious effort was made to provide the reader with meaningful information that is accessible to those who do not work in human services. A further effort was made to provide significant data measures as well as success stories (which do not include identifying information for the privacy of those we serve).

Due to the successful efforts to build an annual report that remains on topic, informational, and concise, this document is "only" 31 pages. The report is meant to be a ready reference, a general guide to what the Human Services department does and the impact that the department has on the community at large in addition to the consumers we serve directly. Reading this report cover to cover will not make the reader an expert in human services, but will inform the reader on the various aspects of service in which the Brown County Human Services Department is engaged. Our hope is that a reader of this report gains a general impression of the breadth of the work of this department, understands the requirement that this department continue to grow and change, and learns of some ways that the department is meeting its needs to adapt and change in order to succeed.

At a recent staff meeting, I had the pleasure of reviewing the department's major successes of 2013 with the personnel in attendance-it took over 10 minutes to review the list and say a sentence or two about each! The vibrant, achievement-oriented culture in this department is something to be proud of. Please understand that we still have a lot of room to improve and grow, and as we do the list of accomplishments, adaptations, and efficiencies will continue to grow as well.

I would like to share some of that list of the department's major 2013 accomplishments, (without specific mention to the tens of thousands of client successes in which the department played a role):

- Adult Protective Services responded to an all-time high need for emergency protective placement and services of vulnerable adults, literally saving more than one life.
- Community Options funding (straight COP) was used more optimally, significantly reducing levy spending and positioning the department for greater funding post-Family Care.
- The Alcohol and Drug Abuse area revamped virtually the entire service delivery model allowing us to eliminate a lengthy waiting list solely through more efficient deployment of resources.
- The Organizational Effectiveness method of quality improvement enhanced collaboration by reducing barriers and "silos" of various divisions began and continues to be applied in the areas of: Child Protective Services, Juvenile Justice, Shelter Care, and Children and Adolescent Behavioral Health Unit.
- The department responded to the needs of children with disabilities, reducing the waiting list for Children's Long-Term Support program by one-third, from 220 to 150 (without adding staffing).
- The Economic Support Unit successfully transitioned energy assistance programming in-house and had an immediate positive impact evidenced by positive community and consumer feedback and an increase in the number of eligible people able to access the service.

- The Child Protective Services unit continued to perform at or near the top among "driver counties" on the objective measurements published by the Wisconsin Department of Children and Families.
- The department began providing internal training and professional development resources for staff and managers through efforts of senior managers within the department.
- Nicolet Psychiatric hospital redesign was taken from concept to full completion. At the time of
 this writing, the facility is currently serving a total of approximately 25 consumers, having had
 an average census of approximately 14 for 2013. The move also creates a more sustainable
 model of care delivery, better reflecting the changing needs of consumers and models of
 care.
- The Economic Support Unit, lead county agency of the Bay Lake Consortium continued to be the best-performing consortium in the state despite periodic challenges with turnover and short-staffing.
- The Long Term Care Unit billed tens of millions of dollars in services with accuracy and precision and had a successful program audit verifying the practices.
- Birth to Three conducted extensive training and planning in preparation for their transition to the Primary Coach Approach which creates a more efficient, sustainable system.
- Shelter Care stabilized under new management and began delivering the Independent Living Skills program internally, optimizing utilization of department resources to serve teens approaching young adulthood.
- Volunteer Services conceptualized, planned, and rolled out the popular new program Parent Pals, linking parents in need with community volunteers for coaching and mentoring.
- Juvenile Justice collaborated with the Sheriff's Department to create the Alternative Protocol which gives our department control of services for youth in need of secure placement and is far more cost-effective when appropriate.
- The innovative Child and Adolescent Behavioral Health Unit grew from a fledgling four position operation to a mature seven positions, serving children with serious behavioral health needs in a more robust fashion.
- The Child Protective Services Unit participated in the Child Abuse Task Force and will
 participate further in 2014 as well as play a role in implementing the resulting
 recommendations.

While this list is not exhaustive it is impressive. Many of these things were new or unique and indicate things that would have been missed opportunities or outright failures if not for the flexibility, dedication, and hard work of the personnel of this department.

Yours truly,

Jeremy Kral Executive Director

Brown County Department of Human Services

County Executive
Troy Streckenbach

<u>Human Services Committee</u>

Patrick Evans, Chair Dan Robinson, Vice-Chair Daniel Haefs Brad Hopp Pat LaViolette

Human Services Board

Thomas Lund, Chair
Paula Laundrie, Vice-Chair
Bill Clancy
John Van Dyck
JoAnn Graschberger
Helen Smits
Craig Huxford
Susan Hyland
Carole Andrews

Executive Director
Jeremy Kral

The Human Services Business Division supports multiple units of Community Programs and the Community Treatment Center. Our customers are the public, funding agencies, vendors, and internal staff. We have been entrusted with public funding and are required to follow the applicable state statutes, policies, manuals and guidelines, as well as guidance issued by the federal government relating to financial management, allowable costs and audits. In order to accomplish these tasks, the Business Unit has embraced the County's LEAN initiative and continually looks to improve process work-flow.

Initiatives and accomplishments:

- Fiscal lead for Bay Lakes Income Maintenance Consortium that includes Door, Marinette, Oconto, and Shawano Counties.
- Performed Representative Payee services for approximately 650 clients.
- Implemented Rep. Payee procedures that reduced the number of checks written by 2,600 per year.
- Implemented billing procedures for Bay Haven CBRF.
- Re-engineered the claims reporting process to enhance transparency and validation of reported claims.
- Re-designed Agency Management cost allocation to include Low Income Energy Assistance program.
- Participated in the implementation of the Electronic Medical Records project.
- Helped develop and analyze RFP for the consolidation of Pharmacy products/services.
- Participated in Representative Payee LEAN event that improved month-end process.
- Created new time study forms used throughout the agency to capture data needed to file accurate claims.
- Decreased the number of checks issued from 2012 to 2013 by approx. 2660 checks.
- Reduced the number of internal mail envelopes going to CTC by accumulating the mail going there in one bin and sending it in one envelope daily.
- Standardized the request forms for weekly spending for the consumers and rents so the process for entering the changes has been more efficient and less chance of error.
- Implement a process improvement by emailing address change forms rather than printing them, improving service to the consumer while reducing cost.

2013 Fiscal Data

Number of Accounts Payable keystrokes:	131,423
Number of checks printed for Representative Payee clients:	31,000
Number of funding source profiles:	125
Number of general ledger accounts:	1,950
Number of Medicaid and Medicare claims billed/rebilled:	50,840
Number of Accounts Receivable transactions:	122,510

CHILDREN & FAMILY SERVICES

Jim Hermans, Child Protection & Juvenile Justice Manager

The Children & Family Services unit consists of Child Protection, Juvenile Justice, Children & Adolescent Behavioral Health, Shelter Care and Volunteer Services. These service areas are grouped administratively for maximal coordination. Each area collaborates with the others to achieve seamless service and best outcomes for clients and agency.

Common Characteristics of these services include:

- Engagement the formation of positive working relationships with those whom we serve
- Client centered service service plans developed with client participation
- Family based services to children provided in the context of their family with parental participation
- Safety client and community are protected
- Least restrictive, local, planned reunification placements of children outside the home are made with the consideration of these elements for best outcomes of children
- Coordinated Service Teams families working together with formal and informal supports
- Permanency for children and families
- Strengthening families stronger families provide the best for children
- Community partnership effective working relationships with other service providers is most efficient and effective, with fewer gaps or overlaps.
- Brown County Human Services Social Workers are the primary service provider for their cases

Children & Adolescent Behavioral Health Unit

The Child and Adolescent Behavioral Health Unit (CABHU) provides a range of services to youth and families involved with Brown County including assessment, case management, therapy, and consultation. Eligible families include those who are referred from Child Protection (CPS) or Juvenile Justice (JJ). Staff in CABHU work closely with CPS and JJ case managers to provide intensive services to clients with mental health needs which cannot be met just by referring them to the outpatient services routinely available in the community. Families prioritized for intervention by this unit include those who have children or adolescents with significant, persistent mental health or behavioral problems resulting in risk to themselves or others, frequent crisis situations, likelihood of continued contacts with law enforcement, or risk of being placed in out of home care. Typically the families are having difficulty accessing services, other services available through community resources have already been tried and were not successful, or the family did not follow through with recommended services in the past and need more intensive intervention or assistance in overcoming barriers to engaging more successfully in services.

Staff members in this unit are also notified of all children and adolescents hospitalized on emergency detentions in Brown County and participate in regular case review meetings with Bellin Psychiatric Center staff to help ensure that these clients receive the appropriate level of aftercare. Many of these families can be served appropriately by connecting them with services in the community or providing other assistance on a short term basis. Some families already have appropriate services in place and are determined to not need ongoing county involvement. Others are offered case management services on a voluntary basis. Finally, depending on the safety concerns and degree of need, some are referred to court, often resulting in 90 day settlement agreements or six month commitments. These clients are required to follow through with treatment conditions, primarily on an outpatient basis, though on occasion longer term stabilization in an inpatient setting such as the state hospital at Winnebago Mental Health Institute may be necessary. CABHU is mandated to provide case management and monitoring of all minors court ordered for treatment, and families have the option to continue working with CABHU voluntarily if needed once the court order expires.

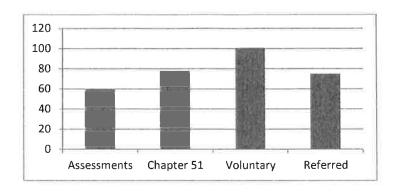
Accomplishments:

- 2013 was a year of growth and change for this unit with the addition of new staff throughout the year. With this capacity we can serve more families while still keeping caseloads low enough to provide the level of service most beneficial to each individual family.
- CABHU provides services to help youth with serious mental health concerns remain in their homes and communities whenever possible and avoid institutional placements. In 2013 we saw a 39% reduction in state hospital costs (\$77,956.78) as compared to the costs in 2012 (\$127,614.72), despite a rate increase.
- We continue to see a downward trend in the number of children and adolescents in our community hospitalized on emergency detentions, from 290 in 2011 to 182 in 2012 to 168 in 2013. Very few clients who received services through CABHU following an emergency hospitalization in 2013 were re-hospitalized within the year.

Clients Served:

CABHU had involvement with a total of approximately 300 families in 2013. The types of service included the following:

- Assessments: Psychological, cognitive, and AODA evaluations provided to children, adolescents, or their parents who were involved with CPS or JJ.
- Chapter 51: Case management and monitoring of youth who were court ordered for mental health treatment.
- Voluntary: Treatment and case coordination provided on a voluntary basis.
- Referred: Families who were not opened for a new episode of service through CABHU
 following an emergency hospitalization because it was determined that they were already
 participating in services or could be referred to appropriate services in the community.



Client Stories:

A little boy was referred to CABHU at five years old because of severe aggression and destructive behavior in school and day care following his father's incarceration. This resulted in loss of day care services and injuries to family members. CABHU teamed with CPS for case management, worked with his mother individually, and coordinated services through a family-centered team approach (CST). His mother worked successfully with Parent Team individualized in-home parent coaching to gain skills, Options provided crisis wraparound service which was eventually no longer needed, and CABHU also worked with the school district to coordinate supports. CABHU staff also arranged for a state trainer in safe restraints and gentle self-defense to work with multiple family members and staff to increase safety in the home. When the family moved from the county they were no longer in regular crisis. They were not in danger of losing their residence due to disturbances, the boy's level of aggression had dramatically decreased, and his mother's parenting skills had dramatically improved.

We have a client who has worked with the Brown County Human Services Department for several years. He is currently diagnosed with Bipolar Disorder; Pervasive Developmental Disorder (PDD); Attention Deficit Hyperactivity Disorder of combined type (ADHD); Oppositional Defiant Disorder (ODD); and Anxiety Disorder. He has also had several past diagnoses that included Asperger's. This client has exhibited violent behaviors during this time. He has destroyed three school classrooms and damaged many items in his home, provider's offices and Bellin Psychiatric Center (BPC). He has runaway into busy streets, refused to work with providers and expressed threats of harm to his family and himself. This client reached a low point in his treatment beginning the end of 2012 and the start of 2013. He was placed at BPC several times, spent time at Brown County Secure Detention, Brown County Shelter Care and participated in a two week stabilization period at Ethan House Group Home. Through this past year Brown County Human Service Department provided the services necessary to avoid an out of home placement for this client. The Child and Adolescent Behavioral Health Unit (CABHU) has worked within the unit, and also with other units such as Juvenile Court and Children's Waiver (CLTWS) to meet this family's many needs. The CABHU staff has provided in home therapy on a weekly basis. Currently CABHU has one worker working closely with CLTWS regarding case management and continuity of services while another worker provides individual therapy to this client's mother every other Wednesday evening at the Community Treatment Center (CTC). The inhome therapy and individual at the CTC as afforded the family the tools needed to keep this client in his home setting. This client is currently doing well as he moves toward adulthood. This client will turn 17 in August and is currently involved with Advocates for Healthy Transitional Living (AHTL) and has a wrap worker through Innovative Services. He has reached the point where he trusts his case manager and accepts they are there to help him reach his goals. He is able to see the effect of his mental

illness on his life and has been able to share with his case manager with CABHU and his case manager at AHTL when he is in need of a "reset" time. Most recently he was able to see that he needed a short time at Bellin Psychiatric. This client will most likely always struggle with his mental health issues; however through the services this unit has been able to provide he has a much greater chance at a productive adulthood. We look forward to continuing to provide services to this family to help this client reach his goals.

Child Protective Services

Child Protective Services (CPS) is a specialized field of the Child Welfare System. CPS intervention is warranted whenever there is a report that a child may be unsafe, abused or neglected, or be at risk of abuse or neglect. The purpose of the CPS system is to identify and alter family conditions that make children unsafe or place them at risk for abuse or neglect.

The scope of Child Protective Services includes Access, Initial Assessment, and Ongoing Services. CPS is an integrated system of intervention that identifies conditions that make children unsafe or that put children at risk of abuse or neglect and then provides services to families to assure that children are safe and protected. CPS accomplishes this by receiving and responding to reports of abuse or neglect, conducting initial and family assessments, developing and implementing protective, safety and case plans, and providing services and case management until cases can be safely closed. The goal of the child protective services system is to support parents/caregivers in making necessary changes to assure that their children are safe and protected.

The goal of Ongoing Case Management is to reduce the number of children in out of home care (foster care, kinship care, treatment facilities) by safely moving children in out of home care to permanency in a timely manner. Case managers coordinate and provide services such as supervised family interactions that enhance parenting capacities that allow children to return home safely. Case managers utilize community resources and informal family supports to assist families to remain together safely. If the needed changes cannot occur, staff develop and execute concurrent plans for alternative forms of permanency, such as adoption to ensure children do not stay in out of home care any longer than necessary.

Ongoing Case Management also works with children in home utilizing in home safety plans, frequent face to face contacts, and collaboration with formal and informal supports. Ongoing utilizes the Ongoing Service Standards set forth by the Wisconsin Department of Children and Families. This sets forth a framework for the ongoing case process and focus on safety, permanence, and well-being for children and their families serviced under Wisconsin Statute Chapters 48 and 938.

The goal of Initial Assessment and Access is to take referrals of child neglect and abuse. Each of these reports is reviewed by a supervisor every day. If the concerns meet the guidelines to be screened in then the case will be investigated. If it does not meet the criteria then it will be screened out and no further action will be taken.

Accomplishments:

- As of December 2013, Brown County has the highest rate of reunification under 12 months in out of home care rate in the State of WI. This indicates that Ongoing Case Management utilizes intensive early on interventions on cases that are received.
- Brown County Ongoing Case Management Unit continued with the implementation of Permanency Roundtables. A permanency roundtable (PRT) is an intervention designed to facilitate the permanency planning process by identifying realistic solutions to permanency obstacles for youth. Key players (a permanency consultant, a master practitioner, a youth's case manager and supervisor, etc.) convene to create individual permanency plans. Preceding the roundtables is an interactive values training session for agency staff focused on issues surrounding permanency, including the importance of individualized permanency planning, the role of effective legal representation, and the value of judicial leadership. The purpose of the evaluations is to document outcomes, to identify components of PRTs associated with positive outcomes, and to provide practice and policy recommendations for achieving permanency for children and youth. The roundtables are focused on children who have been either lingering in out of home care or have had families that struggled to provide them permanence.
- Ongoing Case Management has decreased the amount of external visitations to outside agencies. This allows the individual case manager to conduct the majority of the visits which can lead to more effective case assessment and monitoring of case progress. With this approach the safe reunification rates should increase and the number of children that enter the system again after reunification should decrease.
- We have added Family Support Services. The Family Support Service Worker supports at risk
 families through services which allow children, where appropriate, to remain safely with their
 families or return to their families in a timely manner. In conjunction with case managers assess
 family's needs and the parents' ability to meet child's needs by developing strategies to reach
 the identified goals.

	Initial Contact Timeliness	Initial Assessment Timeliness	Caseworker Contact (March)	Reunification < 12 mos	Adoption < 24 mos	Placement Stability 0-12 mos	Placement Stability 13- 24 mos	Placement Stability 25+ mos	Reentry < 12 mos
Target Standard	95.0%	100.0%	90.0%	76.1%	36.6%	86.0%	65.4%	41.8%	<9.9%
Statewide	81.0%	71.4%	96.8%	77.0%	33.6%	84.9%	64.1%	43.2%	20.4%
Brown	85.2%	99.1%	95.8%	88.6%	27.3%	84.5%	61.5%	36.1%	23.0%

Reports of Child Abuse/Neglect & Investigations by Month

2013 Month	Reports of Child Abuse/Neglect	Reports Investigated
January	422	133
February	333	115
March	396	127
April	476	162
May	477	143
June	322	127
July	296	112
August	315	109
September	425	147
October	446	144
November	400	154
December	372	146
Total	4680	1619

Client Stories:

A young girl who autism and high care needs has been in care since 2009/2010. This child was unable to attend Kindergarten and did in-home intensive therapy services at about 37 hours for the week all of 2012-2013. She entered school in 2013-2014 school years and has been able to attend full time without any issues and performs above what was expected while still getting 15 hours a week of in home services. The girl's mother abandoned her, could not be located since 2011 and subsequently attempts at reunification failed. Her father is incarcerated until 2020. No appropriate family could be located or was willing to care for her. This girl's father is also 68 years old, would be 75 upon release and has struggled to understand what autism is and what his daughter's care needs are. Her foster family was initially only interested in adoption. With some conversation, discussion, realism, and persuasion (2 visits to prison, providing videos, letters, pictures and have deep discussions regarding her needs and best interests) we were able to facilitate the foster family and her father to collaborate and agree to voluntarily proceed with guardianship and get the child permanence in Nov 2013. The guardians send updates regarding the child about every month or two and she is doing excellent.

Our unit worked with a family beginning in 2012, in which the mother was struggling with mental health and AODA concerns and was not able to safety provide care for her children. Her children were placed in out-of-home care with relatives. Since that time, the mother has engaged in services for her mental health. She is taking her medication regularly. She also completed a parenting program and was engaged in learning new ways to parent. The mother also completed AODA programming and the Department has had no concerns regarding any recent drug use. All three children have been returned to her care. The family has been doing well and continued to engage in services after the children returned home. The mother has initiated her own additional individual counseling and group counseling services. She has been able to provide the children with a stable residence and demonstrate that she can meet the needs of her children. Our Department has petitioned to close her case out early as there is no longer a need for CPS involvement. This mom has

been able to accomplish more than she thought was possible and is a now a confident parent. She is very involved in all aspects of her children's lives. She is regularly in contact with their school and has the children involved in extracurricular activities. This mom has made significant life changes that have made her involvement with our Department a great success.

We served a family where there was an isolated incident which resulted in leaving the child with an injury. There were a lot of issues with the child's behaviors in the home. He continued to do well in school but struggled in his home environment. The family was becoming very frustrated and didn't know what to do. Our social worker arranged for the family to receive Parent Team Services. The family successfully completed the parenting section and saw great improvements with the child's behaviors. There was also a wraparound worker provided to work solely with the child. This greatly helped the child's self-esteem, confidence and attitude. The services ended successfully and the child's behaviors have no longer been an issue. As a result of being able to provide in home services to the family, the department did not have to be formally involved. The child was also able to remain in the home with his parents and sister.

We received a referral stating a 13 year-old boy and 11 year-old girl were being left home alone and unsupervised during the day while their mother was at work. The concerns in the referral were regarding the young boy's behaviors. He had been roaming the neighborhood and had been getting into fights. There had been other concerns with the child's mental health and behaviors. After meeting with the mother, she had explained that his behaviors had been out of control and it is a daily struggle. She reported that he had been getting into a lot of fights and trouble in the community. She explained that she is scared because he is heading down the path toward jail. Our worker explained that the department will try to get her some help and services to help with his behaviors. During the time this worker had the case open an email was sent out asking if anyone had a child on their case load that was headed down the wrong path and would benefit from a mentor. They wanted to do a documentary and have the child start down a successful path. Worker summited a referral on behalf of this family. The child had to be interviewed by the producer along with many other children from the community and this child was selected. He was a part of the Character's Unite documentary and Randall Cobb of the Green Bay Packers has been his mentor. They continue to remain in contact and spend time together. This teen also had the opportunity to fly to New York and be on the Today Show.

Independent Living Program

The Independent Living Program (ILP) is a mandated service that is partially funded through the federal John H. Chafee Foster Care Independence Act of 1999. The requirements and funding outlined in the Act are designed to meet the needs of youth that are likely to age out of foster care at age 18 or older, as well as provide services to those youth that have aged out of foster care until their 21st birthday. Services include ongoing case management, assistance with obtaining housing and job seeking. The program also distributes Educational Training Vouchers, provided through the state, to assist in offsetting the cost of tuition, books and other needs for those that choose to attend college.

Client Story:

We served a youth that was placed in out of home care through the juvenile court unit. Due to parental relationships and family dynamics, he was unable to return home and ended up leaving the system after he turned 18. After leaving foster care, he moved in with friends and started "couch surfing". He stopped going to school because he had to work two minimum wage jobs to support

himself. Over time, friends moved out which left the youth homeless and out of options. He then began to accept help and guidance from his former social worker and Independent Living staff. Initially our client was hesitant about independent living groups, however, with time he started attending. He was able to learn about programs and funding available for youth that exited out of the foster care program. Through support of the Independent Living Program and Juvenile Court Unit, this youth has been attending school, working and has an apartment of his own.

Accomplishments:

- Created Fostering Youth Independence (FYI) Mentor Program: The program serves youth that are anticipated to turn 18 while in out of home care or youth that are in need of a mentor.
- Collaboration with UW-Extension to begin ILS Groups: ILS eligible youth are invited to attend
 weekly IL groups at the UW-Extension. Topics include "Rent Smart", interpersonal skills,
 cooking/food safety and mock interviews.

Stats:

25 Independent Living Groups

159 in attendance at IL groups

129 Hours spent with youth planning for their exit from foster care

69 Eligible IL Youth (As of 12/31/2013)

Juvenile Justice Services

The Juvenile Justice Unit consists of one supervisor, 12 staff, and one support staff to process intakes/police reports into the unit and document the case assignments and services provided to the youth and families. Chapter 938 of Wisconsin State Statues guides much of the work done in the unit. 24/7 intake services are provided, conducting intake inquiries on all referrals received, and then working with the youth and families from a least restrictive to most restrictive spectrum.

Accomplishments:

- Created AP (Alternative Protocol) Placement at the secure detention facility in the Brown
 County Jail. This has allowed for services for youth who normally would be ordered to State
 Corrections to be served locally. Since April 2013, 16 youth were placed in AP which has
 resulted in family involvement, closer connections with county caseworkers, and shorter time
 periods of correctional placement for the youth. This was done in partnership with the Brown
 County Sheriff's Department and the Green Bay Public Schools.
- Juvenile Justice Unit came in under budget and has a strategy of doing more direct services themselves. The unit continues to be mindful on spending for vendor services and out of home placements days.
- The staff is very diligent in their work and continue to look for ways to serve their clients the best way possible.

Client Story:

We served a youth who came to the unit with some delinquency referrals. He could not live with his mother who had periods of instability and was in and out of this youth's life. The JJ caseworker found a relative, the grandmother, who was willing to take placement. Supportive services thru a vendor were recommended to support the family. Many rough days were present with the grandmother and grandson having conflict. Support services, the JJ caseworker, and family would meet to solve issues. This youth is very successful now in football, grandmother is going to take guardianship, and there is a permanency plan established for this youth once the juvenile court order ends.

Data:

Per the data below, the Juvenile Delinquency Petitions filed were up from 2012 counts of 181 petitions to 232 petitions filed in 2013. This increase in court related work and the seriousness on the types of cases coming in the door is a trend that must be monitored in 2014.

						JUVEN	ILE COUP	RT INT	AKE S	FATIS	TICS					
	INT	AKE REFER	RAL ACT	IVITY	PAGER A	ACTIVITY					REFERRAL O	UTCOME)			
2013				TOTAL	NON-SECURE	SECURE	TOTAL CASE		NUMBER		DEFERF	RED/INFOR	MAL	RE	FERRED	ТО
	AGE 0 -12 AGE 13 & UP INTAKES			INTAKES	CUSTODY	DETENTION	HANDLED BY	INTAKE CONFERENCE			AGF	REEMENT	JUVE PROS			
MONTH		Del	JIPS	RECEIVED	INTAKE AU	THORIZED	INTAKE UNIT	0 -12	13-UP	TOTAL	0-12	13-UP	TOTAL	0 -12	13-UP	TOTAL
JANUARY	9	49	1	59	20	19	98	3	17	20	1	7	8	1	22	2
FEBRUARY	12	44		56		18	74	2	14	16	1	12	13	1	20	_ 2
MARCH	9	48		57		21	78	8	13	19	q	2	2	0	23	;
APRIL.	19	76		95		36	131	3	19	22	3	9	12	0	36	
MAY	5	53	4	62		15	77	8	22	30	3	- 11	14	0	12	
JUNE	6	34		40		21	81	4	11	15	2	9	11	1	14	
JULY	8	50	2	80		24	84	4	11	15	0	8	8	0	30	
AUGUST	5	34		39		21	80	4	5	9	3	4	. 7	8	15	
SEPTEMBER	2	45		47		38	85	3	θ	11	2	8	10	1	28	1
OCTOBER	14	46	1	61		28	89	4	11	15	0	5	5	3	- 11	
NOVEMBER	7	33	Ĭ	41		25	68	7	7	14		в	7	в	11	
DECEMBER	4	50		54		30	90	2	11	13	1	6	7	2	10	
TOTAL -	100	562	9	671	20	296	983	50	149	199	17	87	104	23	232	2
ERAGE	8,33	46.83	0.75	55.92	1.87	24.67	81.92	4.17	12.42		1.42	7.25		1.92		21.
R MONTH																

DELQ 21	_		BEF	TITIONS R FILED	-			_		_							_				
21	_	_		RFILED	_				CONSE	CONSENT DECREE CO							OURT ORDERS				WV
21	_	TAT/JIP	_		NUMBER FILED					SIGNED DURING MONTH					SIGNED DURING MONTH					1	AD
_	.	-	5	CHIPS	(IPS	TOTAL	DELQ	STAT/JIPS		CHIPS		TOTAL	DELQ	ELQ STAT/JIPS		s	CHIPS		TOTAL	CR	
0.5			+	1	=	22	1	+		+		=	1	11	+		+		=	11	
20	*		+		=	20	1	+		+		=	1	12	+		+	1	=	13	
15	+	1	+		=	16	4	+		+		=	4	7	+		+		=	7	
38	+	1	+		11	39	5	+		+		=	5	15	+		+		=	15	
12	+	1	+		z	13	7	+		+		=	7	12	+	1	+		=	13	
13	+		+		=	13	4	+		+		=	4	15	+		+		=	15	
22	+		+		=	22	1	+		4		=	1	9	+	1	+		=	10	
13	+		+		m	13	3	+		+		•	3	6	+		+			6	
25	÷		+		=	25	7	+		+		=	7	7	+		+		=	7	
16	+	2	+		=	18	4	+		+		=	4	9	+		+		=	9	
15	+	1	+		=	16	3	+		+		2	3	15	+		+		#	15	
15	+		+		×	15		+		+		Û	1	4	+	1	+		п	5	
225	+	6	+	1	п	232	41	+	0	+	0		41	1,22	_		-	4	a	126	
18.75	\dashv	0.5	_	0.083		19.3333	3.417		۵	_	0	-	3,417	10.17		0.25	-	0.083		10.5	0.5
	38 12 13 22 13 25 16 15 15	38 + 12 + 13 + 22 + 13 + 25 + 16 + 15 + 15 + 225 +	38 + 1 12 + 1 13 + 22 + 13 + 25 + 16 + 2 15 + 1 15 +	38 + 1 + 12 + 1 + 13 + + 22 + + 13 + + 25 + + 16 + 2 + 15 + 1 + 15 + + 225 + 6 +	38 + 1 + 12 + 1 + 13 + + 22 + + 13 * + 25 + + 16 + 2 + 15 * 1 + 15 + + 225 + 6 + 1	38 + 1 + = 12 + 1 + = 13 + + = 22 + + = 13 + + = 25 + + = 16 + 2 + = 15 + 1 + = 225 + 6 + 1 =	38 + 1 + = 39 12 + 1 + = 13 13 + = 13 22 + + = 22 13 + + = 13 25 + + = 25 16 + 2 + = 18 15 + 1 + = 16 15 + + = 15 225 + 6 + 1 = 232	38 + 1 + = 39 5 12 + 1 + = 13 7 13 + = 13 4 22 + + = 22 1 13 + = 13 3 25 + + = 25 7 16 + 2 + = 18 4 15 + 1 + = 16 3 15 + + = 15 1	38 + 1 + = 39 5 + 12 + 1 + = 13 7 + 13 + = 13 4 + 22 + + = 22 1 + 13 * + = 13 3 + 25 + + = 25 7 + 16 + 2 + = 18 4 + 15 + 1 + = 16 3 + 15 + + = 15 1 + 225 + 6 + 1 = 232 41 +	38 + 1 + = 39 5 + 12 + 1 + = 13 7 + 13 + = 13 4 + 22 + + = 22 1 + 13 * + = 13 3 + 25 + + = 25 7 + 16 + 2 + = 18 4 + 15 + 1 + = 16 3 + 15 + + = 15 1 + 225 + 6 + 1 = 232 41 + 0	38 + 1 + = 39 5 + + 12 + 1 + = 13 7 + + 13 + + = 13 4 + + 22 + + = 22 1 + + 13 + + = 13 3 + + 25 + + = 25 7 + + 16 + 2 + = 18 4 + + 15 + 1 + = 16 3 + + 15 + + = 15 1 + + 225 + 6 + 1 = 232 41 + 0 +	38 + 1 + = 39 5 + + + 112 + 113 + + = 13 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 113 4 + + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + + 115 4 + 1	38 + 1 + = 39 5 + + = 12 + 1 + = 13 7 + + = 13 4 + + = 13 4 + + = 13 4 + + = 13 4 + + = 13 4 + + = 14 4 + + = 14 4 4 + + = 14 4 4 + + = 14 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	38 + 1 + = 39 5 + + = 5 12 + 1 + = 13 7 + + = 7 13 + = 13 4 + + = 4 22 + + = 22 1 + + = 1 13 * + = 13 3 + + = 3 25 + + = 25 7 + + = 7 16 + 2 + = 18 4 + + = 4 15 * 1 + = 16 3 + + = 3 15 + + = 15 1 + + = 1 225 + 6 + 1 = 232 41 + 0 + 0 = 41	38 + 1 + = 39	38 + 1 + = 39 5 + + = 5 15 + 12 + 1 + = 13 7 + + = 7 12 + 13 + = 13 4 + + = 4 15 + 22 + + = 22 1 + + = 1 9 + 13 + + = 13 3 + + = 3 6 + 25 + + = 25 7 + + = 7 7 + 16 + 2 + = 18 4 + + = 4 9 + 15 + 1 + = 16 3 + + = 3 15 + 15 + + = 15 1 + + = 1 4 + 225 + 6 + 1 = 232 41 + 0 + 0 = 41 122 +	38 + 1 + = 39 5 + + = 5 15 + 1 12 + 1 + = 13 7 + + = 7 12 + 1 13 + = 13 4 + + = 4 15 + 22 + + = 22 1 + + = 1 9 + 1 13 + + = 13 3 + + = 3 6 + 25 + + = 25 7 + + = 7 7 + 16 + 2 + = 18 4 + + = 4 9 + 15 + 1 + = 16 3 + + = 3 15 + 15 + + = 15 1 + + = 1 4 + 1 225 + 6 + 1 = 232 41 + 0 + 0 = 41 122 + 3 +	38 + 1 + = 39 5 + + = 5 15 + + 12 + 1 + = 13 7 + + = 7 12 + 1 + 13 + + = 13 4 + + = 4 15 + + 22 + + = 22 1 + + = 1 9 + 1 + 13 * + = 13 3 + + = 3 6 + + 25 + + = 25 7 + + = 7 7 + + 16 + 2 + = 18 4 + + = 4 9 + + 15 + 1 + = 16 3 + + = 3 15 + + 15 + + = 15 1 + + = 1 4 + 1 + 225 + 6 + 1 = 232 41 + 0 + 0 = 41 122 + 3 + 1 ** ** ** ** ** ** ** ** ** *	38 + 1 + = 39 5 + + = 5 15 + + 12 + 1 + = 13 7 + + = 7 12 + 1 + 13 + = 13 4 + + = 4 15 + + 22 + + = 22 1 + + = 1 9 + 1 + 13 * + = 13 3 + + = 3 6 + + 25 + + = 26 7 + + = 7 7 + + 16 + 2 + = 18 4 + + = 4 9 + + 15 + 1 + = 16 3 + + = 3 15 + + 15 + + = 15 1 + + = 1 4 + 1 + 225 + 6 + 1 = 232 41 + 0 + 0 = 41 122 + 3 + 1	38 + 1 + = 39 5 + + = 5 15 + + = = 12 + 1 + = 13 7 + + + = 7 12 + 1 + = = 13 4 + + + = 4 15 + + = = 12 2 + + = 13 3 + + = 13 3 + + = 13 3 + + = 13 3 + + = 13 3 + + = 3 6 + + = = 14 9 + 1 + = = 15 4 + + = 16 4 + + + = 4 9 + + + = 16 4 + + + = 4 9 + + + = 15 4 + + = 16 3 + + + = 16 3 + + + = 16 3 + + + = 16 3 + + + = 17 7 7 + + + = 16 4 + + + + = 16 3 + + + = 16 3 + + + = 16 3 + + + = 16 3 + + + = 16 3 + + + = 16 3 + + + = 16 4 + + + + = 16 4 + + + + = 16 4 + + + + = 16 4 + + + + = 16 4 + + + + + = 16 4 + + + + + = 16 4 + + + + + = 16 4 + + + + + = 16 4 + + + + + + + + + + + + + + + + + +	38 + 1 + = 39 5 + + = 5 15 + + = 15 12 + 1 + = 13 7 + + = 7 12 + 1 + = 13 13 + = 13 4 + + = 4 15 + = 15 22 + + = 22 1 + + = 1 9 + 1 + = 10 13 + + = 13 3 + + = 3 6 + + = 6 25 + + = 25 7 + + = 7 7 + + = 7 16 + 2 + = 18 4 + + = 4 9 + + = 9 15 + 1 + = 16 3 + + = 3 15 + + = 15 15 + + = 15 1 + + = 16 3 + + = 3 15 + + = 15 225 + 6 + 1 = 232 41 + 0 + 0 = 41 122 + 3 + 1 = 126

Shelter Care

Shelter Care is a non-secure facility owned and operated through Brown County and licensed through the State of Wisconsin. The shelter accommodates up to 20 youth, ages 10-17, and houses both males and females. The youth at Shelter Care are placed through a Juvenile Court judge or intake worker due to abuse and/or neglect or delinquent behaviors.

While at Shelter Care residents participate in programming such as current events, teen issues, independent living and interpersonal skills. Shelter Care residents also have opportunities to participate in outings and community service events throughout the year. A number of outside presenters come to Shelter Care to encourage positive choices. Presenters in 2013 included the Pillowcase Project, Girl Scouts, Golden House and Catholic Charities.

Stats:

314 Residents served

94 Out of County Residents Served

Placement Types

- -85 CHIPS
- 57 JIPS
- 172 Delinquencies

Volunteer Services

Volunteer services primary role is to recruit and train volunteers to assist other units of Human Services. The program's volunteers and interns provide transportation, supervised visitation and mentoring for young children and families. The mentoring programs facilitated through this area are PALS and ParentPALS. These programs are designed to support child protection families and to avoid recidivism of present clients. There are a number of events throughout the year, made possible by community partners, which are available for PALS, ParentPALS as well as foster families. In 2013 the program organized twelve event nights including fitness nights, field trip to the Wisconsin Dells, Bay Beach Picnic and annual holiday party.

Client Stories

The USA Network in conjunction with the National Football League has an anti-bullying campaign called "NFL Characters Unite." This year a child from the Pals Program was selected for a feature story with the Green Bay Packers' Randall Cobb. They filmed for an entire day in October and the story aired on Friday, January 31 on the USA Network. On the Wednesday before the show aired, Randall Cobb and the child from the Pals Program appeared on the Today Show to promote the program. After hearing about the family having a series of bad luck and challenges, at the end of the Today Show, GMC presented the parent of the child with a new vehicle.

In the summer of 2013 WLUK TV – FOX 11 did a feature story on a former Pals match with a volunteer couple, Terry & Jean Eckers. The couple was matched with the child from age 7 through age 18. They assisted him in every phase of his life including school. He secured a job as a caddy at Oneida Country Club, graduated from Green Bay West High School and received the "Chick Evans Scholarship" to attend UW-Madison. He currently is in the Mechanical Engineering Program and is working at an internship with a large, local company.

Accomplishments:

 ParentPals, a collaboration with CPS staff, launched in 2013. The program links mentors with families that have been involved with child protection.

Stats:

29,625 Volunteer Hours

350 Volunteers

140,486 miles driven by Volunteer Drivers

49 Youth waiting to be matched to a PAL

ECONOMIC SUPPORT

Jenny Hoffman, Economic Support Services Administrator

Economic Support Services provide assistance to vulnerable and low-income households in meeting their basic needs for food, healthcare, heating and electric expenses as well as child care costs. Economic Support Services includes the following programs: FoodShare, Medicaid, Badgercare Plus, Caretaker Supplement, Wisconsin Shares Child Care Assistance Program and the Wisconsin Home Energy Assistance Program. These programs are governed under Chapter 16 and 49 of the Wisconsin State Statutes.

The Economic Support staff work with customers to determine their eligibility for the programs outlined above. Each program has its own set of financial and non-financial eligibility criteria. Applications must be processed within 30 days. Eligibility reviews are conducted on a 6 month or annual basis, depending on programs received by the consumer. Changes must also be processed by the Economic Support staff within 10 days of being reported by the customer. The Economic Support staff ensures that customers not only receive their benefits in a timely and accurate manner, but they also assist the consumer with referrals to other services within the community that can assist them in meeting their basic needs.

The Economic Support Specialist and Supervisory positions are highly technical, policy driven positions. New staff training takes approximately 4 months to finish followed by another 4 months of on-the-job training. In addition, state policies and procedures are complex and change oftenweekly, monthly, and annual changes require ongoing and extensive planning, preparing, and training of staff.

<u>Accomplishments</u>

- Implementation of the Patient Protection and Affordable Care Act (PPACA). Funding provided for 10 additional Economic Support positions to assist in the implementation of PPACA. Extensive policy and systems training was completed by all Economic Support staff and supervisors. In addition, management staff participated in numerous meetings with DHS and Consortia staff to ensure implementation was successful. Approximately 2,000 Marketplace/Badgercare Plus applications were received and processed. Finally, an increased number of calls were received by our Call Center due to PPACA. In 2013 the Bay Lake Consortium call center received a total of 37,206 calls which was an increase in 2,000 calls (approximately 5%) from the previous year. These additional calls were received in the last quarter of 2013.
- Administration of the Wisconsin Home Energy Assistance program (WHEAP). Effective 1/1/13, the Economic Support team began administering WHEAP which was previously provided by a community-based vendor agency. A successful transition from the vendor agency to BCHS Economic Support was completed. Extensive planning, preparing, and training were accomplished in a short timeframe. In 2013, we significantly improved customer satisfaction, increased the number of consumers served, and improved overall operations. In addition, we expanded outreach efforts to reach rural consumers and took a proactive approach when assisting consumers in crisis situations.

• Exceeded all State Performance Standards. Economic Support is required to meet several performance standards outlined by the following state departments: Department of Health Services, Department of Children and Families, and the Department of Administration-Division of Energy Services. These performance standards include application timeliness, payment accuracy/quality measurements, customer service and call center standards, identification of client overpayments standards, fraud investigation timeliness, and fraud program cost effectiveness. In 2013, Brown County met and exceeded the performance measures set out by the State.

Client Stories

One individual stated that an Energy staff person was a 'voice of hope' for her family when they were facing a hardship and needed to apply for the Energy Assistance program. She mentioned that she was offered step-by-step guidance as well as referrals for her family to handle the tough situation they were in. She stated our Energy staff person was caring and non-judgmental making a difference for her family.

An elderly gentleman unable to make ends meet on his fixed income was relying on his adult children to support him and was experiencing depression. One of our Economic Support Supervisors provided him and his authorized representative with information on the FoodShare program. He was determined eligible for the program and was able to buy his own food. As a result he was happy that he no longer needed to rely on his family to buy him food, thereby decreasing his depressive symptoms.

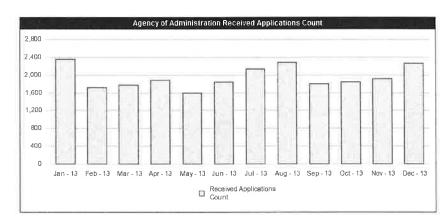
Data/Graphs

- I. Economic Support Applications processed
- II. Economic Support Caseload
- III. FoodShare Recipients served
- IV. FoodShare Benefits issued
- V. Medicaid Recipients served
- VI. Energy Assistance Recipients served and Benefits issued

I. Economic Support Applications processed in 2013 - 23,416

User Selections										
From/To	Month	Year								
From	January	2013								
То	December	2013								
Consortium / Tribal IM Agency	BAY LAKE CONSOR	TIUM								
Agency of Administration	BROWN COUNTY									

Month - Year	Received Applications Count
Jan - 13	2,352
Feb - 13	1,714
Mar - 13	1,773
Apr - 13	1,864
May 13	1,598
Jun - 13	1,847
Jul i- 13	2,131
Aug - 13	2,284
Sep - 13	1,806
Oct - 13	1,849
Nov - 13	1,914
Dec - 13	2,264
Total	23,416



II. Economic Support Total Caseload Count – 23,782

Consortium - County of Residence Report

	User Selections
Year	2013
Month	December
Consortium	BAY LAKE CONSORTIUM

Last Database Refresh Date: 62/28/2014
Links
Report Help
BAY LAKE CONSORTIUM - Worker Level

County of Residence Level Layout											
County of Residence	Active Case Count	Case %									
BROWN COUNTY	23,782	59,93 %									
DOOR COUNTY	2,706	6.82 %									
MARINETTE COUNTY	5,368	13.52 %									
осолто сочиту	3,650	9.20 %									
SHAWANO COUNTY	4,177	10 53 %									
Total Case Count	39,681										

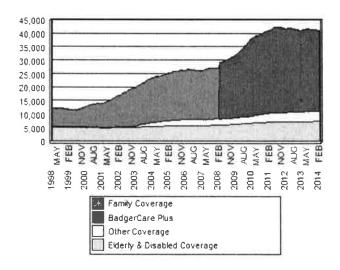
III. Foodshare Recipients served

				STATE	FOOD STAMP FO	WIRCON (SHARE BE) BEJÆFI		TTICIPATION DA	TA .					
Jan 201	3	Feb 2013	Mar 2013	Арг 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Calendar YTD. Mo. Avg. 2013	Calendar YTD. Total 2013
\$ 3,510	951	\$ 3,386,446	\$ 3,451,950	3 491 270	\$ 3,470,033	\$3,455,843	\$3,431,047	\$3,455,190	\$3,410,038	\$3,421,356	\$3,111,718	\$3,058,246		

IV. Foodshare Benefits issued – 2013 -\$40,064,088

WISCONSIN STATE FOOD STAMPIFOODSHARE BENEFITS AND PARTICIPATION DATA RECIPIENTS													
County	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Calendar YTD. Mo. Avg. 2013
Brown	30,548	30,720	30,699	30,939	31,011	31,004	30,831	30,753	30.737	30,679	30,158	29,814	30_658

V. Medicaid Recipients Served - 41,188



VI. Energy Assistance Summary – FFY 2013

	Count	Expenditures	Average Benefit
Total Households Applied for Energy Assistance	6,334		
Total Households Paid Energy Assistance	5,544	\$2,458,479	
Total Households Paid LIHEAP Funded Benefits	5,052	\$1,451,662	\$287
Total Households Paid Public Benefit Funded Benefits	5,532	\$1,006,817	\$182
Total Households Paid Crisis Assistance	477	\$234,451	
Total Households Paid LIHEAP Funded Crisis Applications	291	\$135,275	\$ 465
Total Households Paid Public Benefit Funded Crisis Applications	204	\$99,176	\$486
Total Households Receiving Non Payment Additional Services	10		
Total Households Paid Non-WHEAP Additional Services	89	\$33,890	\$381
Total Heating Unit Repairs Paid	39	\$10,593	\$272
Total Heating Unit Replacements Paid	45	\$111,642	\$2,481

LONG TERM CARE

Lori Weaver, Long Term Care Manager

The Long Term Care division of Brown County Human Services provides support services and case management to over 2,800 constituents in 2013. The division encompasses five areas of service: Birth to 3-Early Intervention, Children's Long Term Support (CLTS), Community Integration Program (CIP), Community Options Programs (COP/COP Waiver), and Personal Care Worker Program.

Birth to 3

Brown County's Birth to 3 program is a voluntary program with a long-standing history and commitment to high quality service provision to infants and toddlers with disabilities and their families. In the June 2013 DHS assessment, the program was identified as achieving 100% compliance for FY2012. Following the review, the program was also charged by DHS with a goal of full implementation of an evidence-based treatment approach, Primary Coach Approach to Teaming, with a target date set by DHS of 1/1/14. This goal was accomplished through a significant amount of planning and support of contracted community providers.

While planning and implementation steps were initiated, the staff (3 FTE's) also received 787 referrals from care providers (primarily physician offices). Direct services are being provided through Federal, state, and mandated county funds to an ever-growing number of Brown County families. In 2013, over 240 families were served on a given day basis as compared to 2012, 217 families and 2011, 197 families. The goal in working with infants, toddlers, and their families to age three is to maximize the child's potential within the parameters developed in partnership with parents.

Services provided by the Birth to 3 Program must be implemented within 45 days of the date of referral. This story reflects the prompt intervention and seamless delivery of service provided to a child

referred summer 2013. Five days after the referral was received, the child was seen. In the county coordinator's assessment, the child was not using words and had sensory issues. A referral was made to contracted providers for therapy and special education instructor evaluations. As a team, an evaluation of determination of eligibility was completed with services initiated on 9/25/2013. Because the child would be age three in less than three months and family concerns about their child's development, the county coordinator also initiated a transition planning conference with the school district immediately after eligibility was determined. The child received services from Birth to 3 until the age of three and the school district worked with the Birth to 3 Program in those three months to ensure a seamless transition to the Early Childhood classroom for continued services through the school district beginning at the child's third birthday.

CLTS Program

The Children's Long Term Support unit provides case management and services within the Medicaid waiver funding provision to children living at home or in the community and who have substantial limitations in multiple daily activities as a result of one or more of the following disabilities: intellectual/developmental disabilities, severe emotional disturbances, and physical disabilities. Funding can be used to support a range of different services that are identified based on an individualized assessment completed by the CLTS case manager. The CLTS unit employed 7 FTE case managers in 2013. Together, the unit provided ongoing case management to 357 consumers and additional sporadic urgent services to some of the 193 eligible children waiting for ongoing long term care funding.

One example of service being provided is to an adolescent with multiple diagnoses ranging from to mental health to developmental disabilities. Before services started, the individual was unable to manage in public school, was aggressive and had significant issues with maintaining appropriate social boundaries. Through services provided by the program and administered by CLTS case manager, the consumer is now thriving in public schools full time, manages aggression without violence and outbursts, has been able to develop appropriate social skills in the community contacts, has created appropriate healthy friendships, and expresses the desire and tries to succeed.

CIP Waiver Program

The Community Integration Program serves adults diagnosed with intellectual and developmental disabilities. The 790 clients of the unit are supported in community settings by 21 case managers. 34 clients were removed from the CIP waitlist and put on services in 2013. The cost for community supports are primarily funded through federal and state dollars, with some local-match dollars when required.

Accomplishments:

 Participation in a DHS data collection pilot project regarding behavioral and mental health symptoms and diagnoses through the Adult Long Term Care Functional Screen (LTCFS). The overall purpose of this project was to enhance the data available to individuals and agencies providing assessment, care management, care planning and service development for long term care applicants and participants. The tool was piloted by Brown County Human Services and seven screening agencies in October and November 2013. Participated in a Readiness for Transitions Pilot Project 2013 through the Wisconsin Board for People with Developmental Disabilities/New Family Care District. The goal of the pilot project was to identify skills, knowledge, motivations, and capacities an individual needs to advocate and to proactively manage/experience life's transitions through facilitating six age-specific focus groups. Five outcomes were identified from the project – a format that allows parent networking on a regular basis, an information and referral system specific to youth with special health care needs, continued learning of "self-directed" supports by this target group, support to a consumer/self-advocate to initiate a mentoring program, and on-going discussion and training of local school districts regarding equal options, informed choice, and the right to self-determination.

Client Story:

After much encouragement by the county case manager, a CIP client finally started in an employment skill development program. Eight years later, the consumer has surpassed job goals, progressing from involvement in a training program and use of a job coach, to sustained independent employment in Brown County. The training experience provided the individual the confidence needed to take other steps toward independence, including progress toward a self-reliant apartment lifestyle. Through additional support of the CIP program, the consumer worked on daily living skills accomplishing tasks many of us take for granted. Things such as money management, grocery shopping, apartment maintenance, and independence in transportation made the completion list. As a result of these great successes, this client was asked and became involved in the Living Mentor grant project as a peer guide.

COP Waiver Program

The Community Options Program provides long term community support for frail elderly and physically disabled adults. The 18 COP unit case managers have provided supports to almost 900 Brown County residents in 2013. This unit manages both the COP-W and CIPII Medicaid Waiver programs as well as the state-funded COP program. Case managers assist individual to remain living in their homes, preventing the need for nursing home care, as well as helping clients relocate out of nursing homes and back into the community.

The COP Unit began working intensively with case managers from the Brown County Community Treatment Center in 2013 to provide community support through the state-funded COP Level 3 program for qualifying individuals with mental illnesses, reducing overall levy expenses by \$400,000. We continued to reduce the amount of people waiting to receive services. Over the year 226 individuals were taken off the long term care waitlist. Many of these individuals qualified for fully funded nursing home relocation dollars.

In 2013, COP staff developed and began implementing a Support and Service Assessment Tool to accurately determine the amount of support needed for individuals living in their own home. This tool allows for case managers to have accurate and specific documentation of support needs while providing consistency throughout the unit. The COP unit also expanded their focus on supporting the

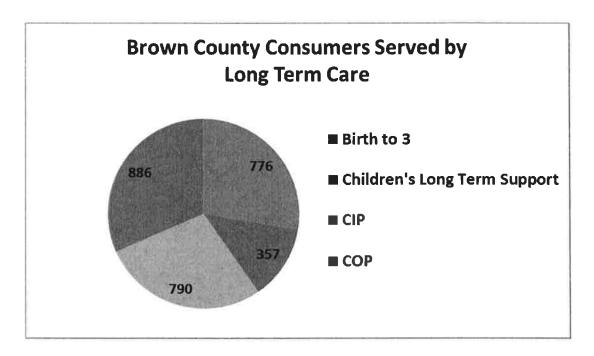
whole individual by working with community agencies. Our case managers collaborate with community providers in hospice services as well as home health care agencies.

Client Story:

One success story that embodies a COP case manager role entails two elderly women who were residing in a local nursing home. Both were found to be eligible for Nursing Home Relocation funding. After meeting in the nursing home, the two became friends. After a few months in the nursing home they realized that they would be unable to return to their previous homes. With supports arranged by their COP case manager, they now share a dwelling at a local residential care apartment complex. They are happy that they now have their own bedrooms and bathroom, but still have support available to help them with daily tasks. They enjoy being roommates and are glad to be out of the nursing home.

Personal Care Worker Program

The four FTE RN personal care workers work in conjunction with adult Long Term Care waiver programs in maintaining the most medically-complex consumers in a community-based setting. The RN's provide ongoing skilled care assessment and monitoring to 306 consumers. The services are billed to Medical Assistance (MA) monthly. The four staff successfully accomplished an increase in the recovery of MA charges from 89.5% in 2012 to 95% in 2013.





BAYSHORE VILLAGE NURSING HOME

Bayshore Village is a licensed 63 bed Medicare/Medicaid certified nursing facility committed to providing its long term care residents quality health care services to maintain their dignity, independence and develop to their full potential. We serve residents of Brown County who have had difficulty being served in other settings. The core values of the nursing home are respect, dignity, and caring. The majority of our referral base is from the community through Adult Protective Services/Crisis Center on an emergency basis. We also accept referrals from Nicolet Psychiatric Center, area medical hospitals, Brown County Human Services Outpatient and Community Programs, and other area nursing homes.

We are staffed by Licensed Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA) 24 hours daily. The nursing staff has long term care experience and many have longevity with the facility. Nursing staff are supervised by the Director of Nursing and Assistant Director of Nursing. We provide an array of ancillary services to include a Medical Director, Social Worker, Registered Dietician, Recreation Therapist, as well as contracted services for Occupational Therapy, Speech Therapy, and Physical Therapy. We also contract with three hospice agencies.

Our census typically remains stable between 61-63 residents. We served 15 residents on Medicare A stays in 2013. We successfully discharged 9 residents to the community in 2013. One of those residents had been here for approximately 1 year and wanted to return home. Through referral to the ADRC as well as assisting as she needed with her application for Social Security Disability, she was found to be eligible for nursing home relocation funding. Once funding was approved and a case manager assigned through the COP program, her transfer home was facilitated.

BEHAVIORAL HEALTH UNIT

lan Agar, Behavioral Health Manager

The Behavioral Health Unit is located at the Community Treatment Center and consists of Adult Behavioral Health and Adult Protective Services.

Adult Behavioral Health

The Adult Behavioral Health Unit addresses the Mental Health and Substance abuse/dependence needs of adult Brown County residents on a community-based, outpatient basis, operating five state certified programs. Staff is comprised of Treatment Providers, Case Managers and Service Facilitators.

Initiatives and accomplishments:

- AODA Services Redesign: Groups for adult clients needing alcohol and drug treatment were
 restructured, to provide a longer degree of support and more substantive programming. This is
 in keeping with best practice, which indicates that the longer someone is maintained in a
 recovery program, the greater the likelihood they will remain abstinent from drug use. This
 redesign also yielded better access to services and reduced waiting lists significantly. These
 services now routinely include the best practices of motivational counseling and Cognitive
 Behavioral Therapy interventions/practices.
- Behavioral Health Case Management Services provision has been largely separated by program type, allowing staff to develop greater expertise in one area, rather than being spread over several programs with multiple sets of rules and regulation, this being confusing to both consumers and staff. We have staff focusing on provision of Targeted Case Management, Comprehensive Community Services, or Community Support Program rather than working across several programs. This effort will be concluded early in 2014, and we anticipate efficiencies from this including improvement in billing practices and client care. These steps were taken after consulting with State personnel last summer, when technical assistance was sought and implemented. These steps will also make implementation of the Integrated Dual Disorder Best practice into programming simpler, as we have staff in dedicated service lines.
- We increased our Dialectical Behavior Therapy skills groups from 1-2, this increasing our capacity. We have staff undergoing additional training to improve the fidelity of these groups to the treatment model, and enabling some of our most challenging clients with Personality Disorders to receive the support and treatment they need. This model adds strength to client coping skills, by teaching and practicing such skills in a supportive group environment.

Adult Protective Services (APS)

Mandated and authorized under Chapters 46, 51, 54, 55 Wisconsin State Statutes, Adult Protective Services staff provide services to protect elderly and vulnerable adults from abuse and/or neglect. Services provided include case management, determination of competency, court petitioning and testimony related to the need for guardianship and/or protective placement.

Initiatives and accomplishments:

 In preparation for the arrival of Family Care and to align our APS staff within the area of our system that makes most structural sense, these staff moved from the Sophie Beaumont location to the Community Treatment Center Outpatient area. This aligns APS with our other

- adult county crisis services. APS staff proximity to MH/AODA and Homeless Outreach staff also provides convenience and a synergy that did not exist under prior system arrangements, and also allowed for CPS office needs to be met at the Sophie Beaumont location.
- APS staff was expanded from 5 to 6 staff due to the growth in need for Emergency Protective Placements in recent years. In 2013, Brown County initiated 29 Emergency Protective Placements, these being situations involving vulnerable adults that have lost capacity to make safe decisions for themselves, or vulnerable to abuse by others, and are at risk due to neglect or self-neglect, often with no support systems to aid them. An additional approximate 15 emergent actions were taken that did not need formal Emergency Protective Placement action. The current workload will increase, when Long Term Care Services are provided by the Family Care MCO, as current LTC staff complete some APS functions. This practice of LTC staff as an extension of APS was established around 2005, when the APS unit was reduced in size from 7 staff and a full time supervisor, to then 5 staff and a fraction of a supervisor's time. The APS supervision is now carried out by the Behavioral Health Manager, this responsibility being added to the role in late 2013. Family Care is likely to increase APS workload due to the LTC services being provided through a 3rd party MCO. Additional numbers of the "Baby Boomer" generation entering retirement are also anticipated to increase the numbers of adults at risk or elder adults at risk in needs of services.
- Additional Volunteer Guardians were trained by APS staff in 2013, this being a growing need. Each "incompetent adult" that lacks funding for a corporate guardian, requires a volunteer guardian, as the county does not have the resources available to pay corporate guardianship fees that are typically close to \$200 per month, per client. APS staff recruit, train and respond to questions from volunteer guardians, this being necessary to make the system work here in Brown County. Guardianship needs are prevalent across the state, and Brown County manages the system well, with little clerical support. Mileage and stipends of \$15 per month are processed for each guardian-ward situation.
- Adult Protective Service Staff were instrumental in assisting the successful prosecution of an
 individual that financially abused a significant number of adults in the county, the financial
 abuse extending to millions of dollars. This was a joint investigation involving local law
 enforcement, the FBI and Adult protective Services staff of Brown County.
- APS staff on at least 1 occasion of note, although there are many such instances, where during follow up visitation, the life of a vulnerable adult was saved, the individual was barely conscious after a fall, and there was a gas leak at the location, requiring evacuation of the area. This person is now in a safe setting and receiving the necessary care.

HEALTH INFORMATION MANAGEMENT

Dawn LaPlant, Health Information Services Manager

The Community Treatment Center Health Information Management Department provides support for a variety of services and programs including inpatient, outpatient, and long-term care. Health Information support includes coding, release of information, deficiency analysis, and transcription. Health Information processes and documentation requirements are governed by State and Federal law and Medicare Conditions of Participation.

Credentialed Coding staff is responsible for reviewing medical record documentation in order to assign a code to the diagnosis. Assignment of the correct diagnosis code is an important step in the revenue cycle process. The diagnosis code is used by payers to determine reimbursement, to gather statistics, and support medical necessity. Staff responsible for release of information handles several requests for copies of medical records on a daily basis. Because we provide mental health and

alcohol/drug abuse services, our release of information processes are governed by HIPAA, additional Federal law and Wisconsin Law. Confidentiality is always a focus. We are also able to charge a fee for copies of medical records. Staff responsible for deficiency analysis review medical records to make sure all required documentation and signatures are complete. Providers are notified of any deficiencies they need to complete, and in 2013 the providers did a great job with deficiency completion. Transcription staff is responsible for transcribing dictated reports such as Psychiatric Evaluations, Discharge Summaries, Social Worker Assessments, and Clinic Notes. Transcription staff also helps type policies and forms. We do continue to have some paper medical records, so Health Information staff scans those papers into the electronic health record.

Accomplishments:

- Omnibus Final Rule The U.S. Department of Health and Human Services (HHS) moved forward to strengthen the privacy and security protections for health information established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The final omnibus rule greatly enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law. In response, we updated policies, the Notice of Privacy Practices, and Business Associate Agreement.
- <u>Electronic Health Record</u> In 2013, there was a renewed project plan to continue to optimize our electronic health record. Efforts in 2013 focused on a system upgrade that was completed in January 2014. We also started preparing for our transition from ICD-9 Clinical Diagnosis codes to ICD-10 Clinical Diagnosis codes.
- Consolidation of Health Information Staff and Outpatient Clerical Staff In 2013 the decision
 was made to consolidate the Health Information Staff and Outpatient Clerical Staff. The
 reporting structure has this group of staff reporting to the Office Manager, and the Office
 Manager reporting to the Health Information Manager. Since many of the duties are similar, it
 is beneficial and efficient to have this group of staff work as one team.

LABORATORY SERVICES

Carol Nowak, Laboratory Services Manager

The laboratory at the facility services the hospital (Nicolet Psychiatric Center), the nursing home (Bayshore Village), the crisis diversion facility (Bay Haven) and the clinical Outpatient departments. Orders for testing are received from the medical doctors and the psychiatrists.

The laboratory is responsible for collecting blood specimens and most of the testing is done "inhouse" within the department. Testing consists of general chemistry and hematology, and routine urine and drug testing. Our department uses Bellin Hospital as a reference lab for tests that need to be sent out and also as a consultant from the pathologists if there are any questions.

This laboratory is licensed and inspected every two years by the State of Wisconsin Department of Health Services and follows the guidelines of the Centers for Medicare and Medicaid Services (CMS) and the Clinical Laboratory Improvement Amendments (CLIA).

Accomplishments:

- This department helped in the streamlining for ordering tests on NPC by helping to go "paperless". We worked with the staff to get accurate ordering of tests required.
- We successful worked with the BSV nursing home to improve the amount of times we had to approach a client for blood draws. With the help of the medical doctor and the nurses we devised a plan to review tests ordered and tried to combine them so that the client did not have to be approached so often to get there blood taken, relieving the hardship of multiple blood draws.
- We worked with the outpatient department to help act as a conduit and help for the clients
 that where discharged from NPC and transition over to the outpatient department. This
 included taking the time to question how they were feeling with the medications they were
 on, their concerns and questions. They have to have their medications monitored through
 blood testing so it is a good time to see how they are doing. We refer clients to nurses or
 doctors if there were any issues.
- In 2013 we served 3,255 clients, with referrals coming from inpatient and outpatient. This amounted to 23,361 in-house tests on blood samples along with urine testing and general drug screen testing.

Client Story:

One of the highlights for us was being able to help a client that was having trouble with the medications she was on and was starting to lose touch with everyone. We alerted the case manager that she was not taking her medications and he responded by assisting the client in being admitted to Nicolet Psychiatric Center. This collaboration assisted the woman in remaining safe through a crisis. This sort of communication is the norm when lab personnel observe a consumer who appears to be struggling.

NICOLET PSYCHIATRIC CENTER & BAY HAVEN CBRE

2013 was a very adventurous and interesting year for Nicolet Psychiatric Center that brought along significant changes that had been in the works since 2011. Plans were finalized to downsize Nicolet Psychiatric Center from the current 35-bed status to 16 beds and to construct a 15-bed community-based residential facility for crisis stabilization. Construction started in September of 2013, at which time Nicolet Psychiatric Center downsized to 16 beds, thus removing our Institution for Mental Disease (IMD) status. Construction was completed and Bay Haven CBRF was opened on December 16, 2013. The opening of the crisis diversion CBRF allowed us to provide another option in our continuum of care for clients needing psychiatric care and stabilization.

During 2013, Nicolet Psychiatric Center admitted 1,121 individuals for treatment for acute psychiatric problems. Another major change that we implemented in the year 2013 was that we made a concerted effort to start admitting people more on a voluntary basis versus having them go through the EM-1 process. We were successful in this venture, as for the year of 2013 we admitted 224 individuals on a voluntary basis. This is compared to admitting only 79 individuals on a voluntary basis in 2012. Average length of stay for 2013 was four days, and our average daily census for the year was 13.

NUTRITIONAL SERVICES

Meghann Reetz, Nutritional Services Manager

The Nutritional Services Department of the Brown County Community Treatment Center provides home cooked meals and snacks for Bay Shore Village, Bay Haven and Nicolet Psychiatric Center. In 2013 we served 82,170 client meals throughout the facility. In addition, we served 149 special function meals and 198 employee visitor meals. In 2013 we also prepared 22,731 snacks and nourishments for the nursing home in addition to snacks and food items that are left on the units for each household or unit to have available between meals.

Since switching from 8-hr to 10-hr shifts in 2012, the department has been able to increase the amount of scratch cooking completed; this has allowed for better control of ingredients used in foods which is helpful when cooking for people who come in with different food allergies. This has also helped us to improve the quality of the food items served. We consistently hear how good our food is at our facility from both clients and outside visitors. For example, one client will frequently tell me that "the food here is better than at the old building" and while another client is always quick to compliment the cranberry pork loin and homemade pies. In addition to clients, we have received compliments from the teacher who oversees the nursing students; she mentioned to me that the food at our facility is some of the best she has ever seen in a nursing home. Also, family members have told me how nice it is to see their family member who lives here receive a burger that was grilled outside and then modified in texture to meet their swallowing needs. Clients on the hospital and CBRF are often pleasantly surprised to find out that we serve foods such as quinoa and edamame which fit well into the vegan and vegetarian diets of many of the clients.

Client Story:

The dietary department received a referral from a client on NPC due to lack of meal intake while on the unit. When speaking with the client it was discovered that this person did not like many foods and was getting anxious that there were not foods in the facility that would meet their preferences. After talking with this person, we were able to develop a list of foods that were available on site and were acceptable to them. The client seemed a little relieved by the time we ended our discussion. When following up a few days later to check on the client and see how things were going with meal intakes, the client had a huge smile on their face and thanked us for working with them to find foods that they wanted to eat. For this particular person, it seemed that the task of finding foods that met their preferences was enough of a "win" to help get the rest of their treatment and recovery rolling.

Accomplishments:

- We had our second consecutive site-free state survey for the nursing home in 2013.
- We have decreased our overall operating expenses nearly 10% from 2012 (\$816,158) to 2013 (\$737,475).
 - *See Figure 1. In order to determine the overall difference in budget I pulled out paid leave earnings (5102), overtime (5103), salary reimbursement for STD (5109), and fringe benefits (5110) accounts because they were not allocated to my department in 2012 meaning I could not accurately compare 2012 vs. 2013 in these areas.
- We held outdoor picnics for the residents of Bay Shore Village. Our department worked with the activity and nursing departments to create a new activity for the residents that included

watching (and smelling) the kitchen staff cook burgers and brats on charcoal grills outdoors, playing trivia games, and enjoying the beautiful outdoors, including the new garden that was planted by the master gardeners. This was especially nice for our department because we had the opportunity to provide char-grilled burgers and brats (usually cooked inside in our Combi oven) that were cooked following food safety guidelines to the entire facility. We had great feedback from the clients and client family members stating that they enjoyed the activity; family members reported that they were happy to see their family member received the grilled foods even if they required a texture altered diet.

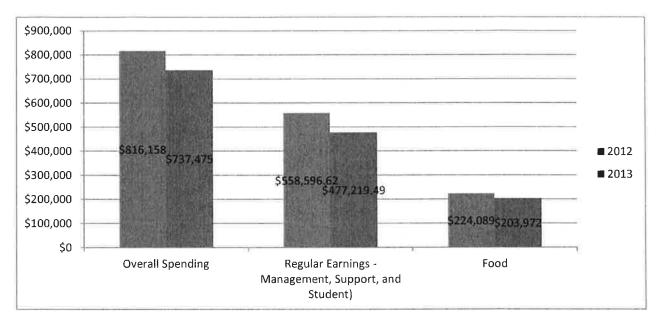


Figure 1. 2012 vs. 2013 Dietary and Nutritional Services Budget Highlights